



**RELEASE & DISCLAIMER**

**Name:**..... **Preferred name (if different)**.....  
**Home Address:**.....  
**Suburb:**..... **Postcode:**.....  
**Telephone No:(M)**.....**(W)**.....**Pager**.....  
**Emergency Contact Name:** ..... **Emergency Contact No:**.....  
**Occupation/Position Title:** .....  
**Department:**..... **Campus**.....  
**Email Address at Monash Health**.....**@monashhealth.org**  
**Other Email Address:** .....  
**Employee/Student No**..... **ID Card No**.....  
**Date of Birth:** ..... **Male/Female** (Please circle)

**Indemnity Clause**

1. I, ....., being a member of Healthwise Fitness at Monash Health, hereby declare that, except for any disability or condition which I have disclosed to Healthwise Fitness, I do not have any physical, mental or other disability or condition which may or could be affected or aggravated; or otherwise result in loss, damage or deterioration to my health as a result of my use of the Healthwise Fitness facilities, including its equipment.
2. I hereby indemnify and release Healthwise Fitness from any claim for all or any loss, damage or injury whatsoever that I may suffer through my use of the Healthwise Fitness facilities, including damage to hand held electronic devices and personal property, however caused.
3. I hereby indemnify and release Healthwise Fitness from all claims, actions, demands and/or proceedings arising out of my using Healthwise Fitness facilities, including its equipment.
4. I understand that I am responsible for monitoring my own condition during my use of Healthwise Fitness facilities. If I feel unwell or distressed, I will cease participation and inform the Healthwise Fitness staff of my symptoms
5. I agree to abide by the Gym Membership Etiquette and Membership Policy in place at Healthwise Fitness.
6. I have read and understood the content if this Release & Disclaimer form, and hereby consent to all its contents.

Signed.....(Member) Date:.....

## Physical Activity Readiness Questionnaire (PAR - Q) & YOU

Many health benefits are associated with regular physical activity. Being more active is safe for most people. However, some people should check with their doctor before they start becoming more physically active. If you are between ages 15 and 69, the PAR Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, please check with your doctor.

Please answer the following questions by ticking the appropriate boxes:

Name (please print) \_\_\_\_\_

- | YES                      | NO                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a Heart condition, High blood pressure, Rheumatic Fever, Stroke, High Cholesterol, Palpitations, Murmurs or pain in the chest? |
| <input type="checkbox"/> | <input type="checkbox"/> | In the past month, have you had chest pain?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had any injury, illness back or joint condition that may be aggravated by exercise?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Arthritis, Asthma, Diabetes, Epilepsy, Hernia, Dizziness, Gout, circulation problems or an Ulcer?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Have your mother, father, brother/sister had any heart problems prior to age 50?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you now or have recently been pregnant?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you lose balance because of dizziness or do you ever lose consciousness?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking any prescribed medication?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of <u>any other reason</u> why you should not do physical activity?  |



### YES to one or more questions...

- Check with your doctor **BEFORE** you start exercising or before you have a fitness appraisal at the Fitness Centre. Tell your doctor about the PAR Q and which questions you answered YES.
- Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.

### NO to all questions...

- You can be reasonably sure that you can commence becoming more physically active – begin slowly and gradually build up.
- Take part in a fitness appraisal to determine your basic fitness level, so you can plan the safest and most effective way to achieve your goals.

### DELAY BECOMING MORE ACTIVE IF:

- If you are not feeling well due to temporary illness eg a cold, wait until you feel better.
- If you become pregnant – talk to your doctor and inform fitness centre staff prior to continuing exercise.

**PLEASE NOTE: If your health changes so that you answer YES to any of the above questions please notify Fitness Centre Staff. Ask whether you should change your physical activity plan.**

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of witness \_\_\_\_\_ Name of Witness \_\_\_\_\_

### MEDICAL HISTORY AND PRESENT MEDICAL CONDITIONS

Please tick, if you have or have had any of the following conditions:

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease, Cardiac Surgery or Coronary Bypass | <input type="checkbox"/> Diabetes                  |
| <input type="checkbox"/> Stroke, Heart Murmur, Peripheral Vascular Disease | <input type="checkbox"/> Cancer                    |
| <input type="checkbox"/> High Blood Pressure >140/90                       | <input type="checkbox"/> Hernia                    |
| <input type="checkbox"/> Blood Disease of any kind                         | <input type="checkbox"/> Asthma                    |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Anaemia                   |
| <input type="checkbox"/> Migraine, or recurrent headaches                  | <input type="checkbox"/> Foot Problems             |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Light headedness/fainting                         | <input type="checkbox"/> Shoulder Problems         |
| <input type="checkbox"/> Ulcers, Stomach or Intestinal Problems            | <input type="checkbox"/> Broken Bones              |
| <input type="checkbox"/> Swollen, stiff or painful joints                  | <input type="checkbox"/> Knee Problems             |
| <input type="checkbox"/> Back Problems                                     | <input type="checkbox"/> Skin infection            |
| <input type="checkbox"/> Family History of Heart disease                   | <input type="checkbox"/> Neck Problems             |
| <input type="checkbox"/> Pelvis/Hip Problems                               | <input type="checkbox"/> Pregnant                  |
| <input type="checkbox"/> Shortness of Breath                               | <input type="checkbox"/> Fatigue or lack of energy |
| <input type="checkbox"/> Other   |  |

If you ticked any of these, please explain further:

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Date of most recent full medical check up

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Have you ever had high cholesterol?

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Please list any prescribed medications you are now taking

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Please list any illness, hospitalisation, or surgical procedure within the past 2 years.

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